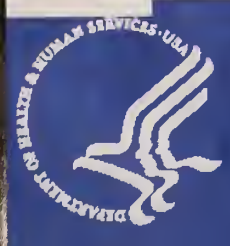
1999 Guide

To Health Insurance for People with Medicare

A Guide For :

- Purchasing Medigap Insurance
- Using Medigap Insurance
- Other Kinds of Health Insurance

Developed jointly by the
National Association of Insurance Commissioners
and the
Health Care Financing Administration of the U. S. Department of Health and Human Services



HEALTH CARE FINANCING ADMINISTRATION

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If You Have Questions

The Guide To Health Insurance for People with Medicare supplements the Medicare handbook, now called *Medicare & You*. This guide's primary purpose is to offer you help in purchasing and using Medicare supplemental or Medigap insurance.

We have included information on some of the most frequently asked questions about the Original Medicare Plan and Medicare supplemental policies. Check the index on page 59 for the information you need. The index provides an alphabetical listing of all the major topics discussed in this guide. If your questions are not answered, use the telephone directory starting on page 47. Telephone numbers for each of the State Agencies on Aging, State Health Insurance Assistance Programs, and the state insurance departments are listed in the directory. These organizations can help you with questions you may have about most health insurance issues.

If you are a new Medicare beneficiary, the Medicare handbook is automatically mailed to your house around the same time as your Medicare card. Starting in late 1999, all other beneficiaries will receive a copy of the Medicare handbook each year in the mail.

What's New in 1999?

This guide is completely redesigned; we hope it is easier to use. HCFA welcomes your comments and suggestions about *The Guide To Health Insurance for People with Medicare*. We may be unable to respond to all comments, but your comments may help us make improvements to future versions of this guide.

Send your comments to:
Health Care Financing Administration
Guide To Health Insurance Comments
7500 Security Boulevard
Baltimore, Maryland 21244-1850

HCFA publishes a number of booklets and pamphlets on specific parts of the Medicare program. You can request these publications by calling the Medicare Hotline at 1-800-638-6833. You can also see or print them from the internet at www.medicare.gov.

What Is "Supplemental" Or Supplemental Insurance?

There are many types of private health insurance/coverage that will pay for some or all of your health care costs not covered by Medicare. These types of private health insurance/coverage include:

- Employee Coverage (from your employer or union);
- Retiree Coverage (from your employer or union); and
- Medigap Insurance (from a private company or group).

People often refer to all of these types of private health insurance/coverage as "supplemental." However, "Medicare Supplemental" or "Medigap" insurance is a specific type of private insurance that is subject to federal and state laws.

This guide can give you some useful information on all the types of supplemental insurance/coverage discussed above. However, the main focus of this guide is to provide you with important information about Medigap insurance.

How Do You Know If Your Supplemental Insurance Is A Medigap Policy?

Medigap insurance is specifically designed to fill "gaps" in Original Medicare Plan coverage. It will generally not pay benefits if you are enrolled in a Medicare health plan (e.g. Medicare Managed Care Plan or HMO). Any policy that is a Medigap policy will be clearly identified as "Medicare Supplemental Insurance". Medigap policies provide specific benefits that are grouped in 10 standardized Medigap plans (see page 14).

If you aren't sure if your supplemental insurance/coverage is a Medigap policy, ask your insurance company or check your policy.

Caution

Do You Need A Medigap Policy If You Are On Medicaid?

- If you are on Medicaid, you do not need a Medigap policy. In fact, it is illegal for anyone to sell you a Medigap policy if they know you are on Medicaid.
- If you already have a Medigap policy and go on Medicaid, see page 43.

What Is In This Guide?

Original Medicare Plan:
The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan.

Medigap:
A Medicare supplemental insurance policy that is sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. There are 10 standardized policies, labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Medicare SELECT:
A type of Medigap policy that must meet all of the requirements that apply to a Medigap policy, and may require you to use doctors and hospitals within its network in order for you to be eligible for full benefits.

* Throughout the rest of this book, the term "Medicare supplemental insurance policy" will be referred to as "Medigap policy".

Highlighted words are defined in this column throughout this Guide, and can be found in the Glossary Of Terms on page 55.

The Original Medicare Plan pays for much of your health care, but not all of it. To get more coverage, you may have an employer or union sponsored health plan or you may purchase a Medicare supplemental insurance policy from a private insurance company (also known as Medigap or Medicare SELECT)* or you may consider joining a Medicare health plan.

The National Association of Insurance Commissioners (NAIC) and the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services have written this guide to give you information that should help you:

- Learn about Medicare and Medigap.
- Identify what the Original Medicare Plan does not cover in full or at all (the gaps in your coverage).
- Decide whether or not to purchase a Medigap policy if you have the Original Medicare Plan.
- Know what is important to consider when purchasing a Medigap policy.
- Learn about using Medigap policies and other related issues.
- Find the name and telephone numbers of state agencies that can answer your questions about health insurance.

This guide does not recommend insurance companies or policies.

Words that may be new to you are explained the first time they are used. If you want to know more about new words, you can look in the "Glossary" on page 55. In the glossary, many of the words used in this guide are defined more completely.

How To Use This Guide

The Guide has 4 sections:

Section 1 - Let's Start With The Basics: The Original Medicare Plan

- What is covered;
- What are the gaps; and
- How to get more coverage and/or reduce out-of-pocket costs.

Section 2 - Purchasing a Medigap Policy

- What Medigap covers;
- The types of Medigap policies available;
- Medigap benefits;
- The best time to buy; and
- Medigap for people under age 65.

Section 3 - Using Medigap Insurance

- Filing claims;
- Protections and guarantees;
- Switching policies; and
- Other protections.

Section 4 - Other Kinds Of Health Insurance

- Group insurance;
- Employee coverage;
- Retiree coverage;
- Medigap and retiree coverage;
- Special rules for those with employed spouses;
- Other options; and
- Long-term care insurance.

Gaps:
The costs or services that are not covered under the Original Medicare Plan.

Out-of-Pocket Costs:
Health care costs that you must pay on your own because they are not paid by Medicare (see page 7).

Protections and Guarantees:
Your rights to buy Medigap coverage in certain cases (see page 30).

Long-term Care:
Custodial care provided at home or in a nursing home for people with chronic disabilities and prolonged illness. Long-term care is not covered by Medicare.

Deductible:
The amount you must pay before Medicare begins to pay:
- each benefit period for Part A;
- each year for Part B.

Coinsurance:
The percent of the Medicare-approved charge that you have to pay:
- after you pay the Part A deductible;
- after you pay the $100 deductible each year for Part B.

Premium:
Periodic payment for health care coverage to:
- Medicare,
- an insurance company, or
- a health care plan.

Fiscal Intermediary:
A private company that has contracted with Medicare to process bills and pay claims for Part A services.

Medicare Is A Health Insurance Program For:

- People 65 years of age and older.
- Certain people with disabilities under age 65.
- People with End-Stage Renal Disease (ESRD), (people with permanent kidney failure who need dialysis or a transplant).

What Is The Original Medicare Plan?

The Original Medicare Plan is the traditional pay-per-visit arrangement. You can go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay the deductible. Then Medicare pays its share, and you pay your share (coinsurance). The Original Medicare Plan has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

What Is Part A (Hospital Insurance)?

Part A (Hospital Insurance) helps pay for care in hospitals and skilled nursing facilities, and for home health and hospice care. If you are eligible (see below), Part A is premium free. That is, you don't pay a premium because you or your spouse paid Medicare taxes while you were working. Your Fiscal Intermediary can answer your questions on what Part A services Medicare will pay for and how much will be paid (see page 46).

You are eligible for premium-free Medicare Part A (Hospital Insurance) if:

- You are 65 or older. You are receiving or eligible for retirement benefits from Social Security or the Railroad Retirement Board, or
- You are under 65. You have received Social Security disability benefits for 24 months, or
- You are under 65. You have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or
- You or your spouse had Medicare-covered government employment, or
- You are under 65 and have End-Stage Renal Disease (ESRD).

If you don't qualify for premium-free Part A, and you are 65 or older, you may be able to buy it. Contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

Medicare Carrier:
A private company that contracts with Medicare to process beneficiary bills (claims) for Part B services.

What Is Part B (Medical Insurance)?

Part B (Medical Insurance) helps pay for doctors, outpatient hospital care and some other medical services that Part A doesn't cover, such as the services of physical and occupational therapists. Part B covers all doctor services that are medically necessary unless you get them from doctors with whom you have a private contract (see page 29). Beneficiaries may get these services anywhere (a doctor's office, clinic, nursing home, hospital, or at home). Your Medicare carrier can answer questions about Part B services and coverage (see pages 51-52).

You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible if you are a United States citizen or permanent resident age 65 or older. Part B costs $45.50 per month in 1999.

Part B is voluntary. If you choose to have Part B, the monthly premium is deducted from your Social Security, Railroad Retirement, or Civil Service Retirement payment. Beneficiaries who do not get any of these payments are billed by Medicare every 3 months.

If you didn't take Part B when you were first eligible, you can sign up during 2 enrollment periods:

- **General Enrollment Period**: If you didn't take Part B, you can only sign up during the General Enrollment Period, January 1 through March 31 of each year. Your Part B coverage is effective July 1. Your monthly Part B premium may be higher. The Part B premium increases 10% for each 12-month period that you could have had Part B but did not take it.

- **Special Enrollment Period**: If you didn't take Part B because you or your spouse currently work and have group health plan coverage through your current employer or union, you can sign up for Part B during the Special Enrollment Period. You can sign up at any time you are covered under the group plan. In addition, if the employment or group health coverage ends, you have 8 months to sign up. The 8-month period starts the month your employment ends or the group health coverage ends, whichever comes first. Generally, your monthly Part B premium is not increased when you sign up for Part B during the Special Enrollment Period. Contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778), or the Railroad Retirement Board at 1-800-808-0772 to sign up for Part B.

Deductible:
The amount you must pay before Medicare begins to pay:
- each benefit period for Part A;
- each year for Part B.

Coinsurance:
The percent of the Medicare-approved charge that you have to pay:
- after you pay the Part A deductible;
- after you pay the $100 deductible each year for Part B.

Assignment:
In the Original Medicare Plan, a process through which a doctor or supplier agrees to accept the amount Medicare approves as payment in full. (You must pay any coinsurance amount.)

For more information about:
- purchasing a Medigap policy, see Section 2, page 12
- using Medigap insurance, see Section 3, page 28
- other kinds of health insurance, see Section 4, page 35
- Medicare health plan choices, see Appendix, page 53.

What Are Your "Out-of-Pocket" Costs?

The Original Medicare Plan pays for much of your health care, but not all of it. (See Medicare Part A (Hospital Insurance) covered services and Medicare Part B (Medical Insurance) covered services on page 8-9). Your "out-of-pocket" costs for health care will include your monthly Part B premium ($45.50 per month in 1999). You will have to pay deductibles and coinsurance when you get health care services.

Generally, you will pay for your outpatient prescription drugs. You also pay for routine physicals, nursing home (custodial) care, most dental care, dentures, routine foot care, and hearing aids. There are yearly limits on what Medicare will pay for physical therapy and occupational therapy services unless you get them in a hospital outpatient department, or through home health agencies. The Original Medicare Plan pays for some, but not all, preventive care (see page 10).

Your Out-of-Pocket Costs May Depend On:

- Whether your doctor accepts assignment.
- How often you need health care.
- What type of health care you need.

How Can I Get More Coverage and/or Reduce My Out-of-Pocket Costs?

- Keep your employer or union sponsored health coverage, or
- Buy a Medigap policy, or
- Join a Medicare health plan other than the Original Medicare Plan (see Appendix, page 53).

Caution

Any decision about your health care is an important one. You should make your decision carefully and with the help of people you trust. If you or your spouse currently have employer or retiree health coverage that supplements Medicare, check the information provided by your employer or union, and contact them before you choose a new plan. If you have Medigap coverage, check the information provided by your Medigap insurance company, or call the State Health Insurance Assistance Program in your State before you choose a new policy (see page 48). If you have Medicaid coverage, do not make changes until you contact your State Medical Assistance Office (see page 46).

Medicare Part A (Hospital Insurance) Covered Services

Covered Services	What You Pay in 1999
Hospital Stays: Semiprivate room, meals, general nursing and other hospital services and supplies (but not private duty nursing, a television or telephone in your room, or a private room unless medically necessary).	For each benefit period you pay: ■ A total of $768 for a hospital stay of 1-60 days. ■ $192 per day for days 61-90 of a hospital stay. ■ $384 per day for days 91-150 of a hospital stay.* ■ All costs for each day after 150 days.
Skilled Nursing Facility (SNF) Care**: Semiprivate room, meals, skilled nursing and rehabilitative services, and other services and supplies.	For each benefit period you pay: ■ Nothing for the first 20 days. ■ Up to $96.00 per day for days 21-100. ■ All costs after day 100 in the benefit period. Call your Fiscal Intermediary with questions about skilled nursing facility care and conditions of coverage (see page 46).
Home Health Care**: Intermittent skilled nursing care, physical therapy, occupational therapy, speech language pathology services, home health aide services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers) and supplies, and other services.	You pay: ■ Nothing for Home Health Care services. ■ 20% of approved amount for durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers). Call your Regional Home Health Intermediary with questions about home health care and conditions of coverage (see page 46).
Hospice Care**: Pain and symptom relief, and supportive services for the care of a terminal illness. Home care is provided. Also covers necessary inpatient care and a variety of services usually not covered by Medicare.	You pay: ■ Limited costs for outpatient drugs and inpatient respite care (care given to a hospice patient so that the usual care giver can rest). Call your Regional Home Health Intermediary with questions about hospice care and conditions of coverage (see page 46).
Blood: From a hospital or skilled nursing facility during a covered stay.	You pay: ■ For the first 3 pints.

Benefit Period: Starts the day you go to a hospital or skilled nursing facility and ends when you haven't received hospital inpatient or skilled nursing facility care for 60 days in a row.

* You have 60 lifetime reserve days that may only be used once. For each reserve day, Medicare pays all covered costs except for a daily coinsurance ($384 in 1999).

** You must meet certain conditions for Medicare to cover these services.

Call your Fiscal Intermediary for general questions about your Medicare Part A coverage (see page 46).

Medicare Part B (Medical Insurance) Covered Services

Covered Services	What You Pay in 1999
Medical Expenses: Doctors' services, inpatient and outpatient medical and surgical services and supplies, physical, occupational and speech therapy, diagnostic tests, and durable medical equipment (DME).	You pay: ■ $100 deductible (pay once per year). ■ 20% of approved amount after the deductible, except in the outpatient setting. ■ 50% for most outpatient mental health. ■ 20% of first $1,500 for all physical therapy services and 20% of first $1,500 for all occupational therapy services, and all charges after that. (Hospital outpatient therapy services do not count towards limit.)
Clinical Laboratory Service: Blood tests, urinalysis, and more.	You pay: ■ Nothing for services.
Home Health Care: (under certain conditions.) Intermittent skilled care, home health aide services, DME and supplies, and other services.	You pay: ■ Nothing for services. ■ 20% of approved amount for DME.
Outpatient Hospital Services: Services to find, or treat an illness or injury.	You pay: ■ No less than 20% of the Medicare payment amount (after the deductible).
Blood: As an outpatient, or as part of a Part B covered service.	You pay: ■ For the first 3 pints plus 20% of approved amount for additional pints (after the deductible).

Note: Actual amounts you must pay for coinsurance are higher if the doctor does not accept assignment (see glossary). Call your Medicare carrier if you have questions about your Medicare Part B coverage (see pages 51-52).

Part B also helps pay for:

- X-rays
- Speech language pathology services
- Artificial limbs and eyes
- Arm, leg, back, and neck braces
- Kidney dialysis and kidney transplants
- Under limited circumstances, heart, lung, and liver transplants in a Medicare-approved facility
- Preventive services (see page 10)
- Very limited outpatient drugs
- Emergency care
- Limited chiropractic services
- Medical supplies: items such as ostomy bags, surgical dressings, splints, and casts
- Breast prostheses following a mastectomy
- Ambulance services (limited coverage)
- The services of practitioners such as clinical psychologists, clinical social workers, and nurse practitioners
- One pair of eyeglasses after cataract surgery with an intraocular lens

Medicare Preventive Services - Added Benefits to Help You Stay Healthy

Covered Service	Eligible Beneficiaries	What You Pay in 1999
Screening Mammogram: Once per year.	All female Medicare beneficiaries age 40 and older.	20% of the Medicare-approved amount with no Part B deductible.
Pap Smear and Pelvic Examination: (Includes a clinical breast exam) Once every three years. Once per year if you are high risk for cervical or vaginal cancer, or if you are of child bearing age and have had an abnormal Pap smear in the preceding three years.	All female Medicare beneficiaries.	No coinsurance and no Part B deductible for the Pap smear (clinical laboratory charge). For doctor services and all other exams, 20% of the Medicare-approved amount with no Part B deductible.
Colorectal Cancer Screening: Fecal Occult Blood Test: Once every year. Flexible Sigmoidoscopy: Once every four years. Colonoscopy: Once every two years if you are high risk for cancer of the colon. Barium Enema: Doctor can substitute this for sigmoidoscopy or colonoscopy.	All Medicare beneficiaries age 50 and older. However, there is no age limit for having a colonoscopy.	No coinsurance and no Part B deductible for the fecal occult blood test. For all other tests, 20% of the Medicare-approved amount after the annual Part B deductible.
Diabetes Monitoring: Helps pay for glucose monitors, test strips, lancets, and self-management training.	All Medicare beneficiaries with diabetes (insulin users and non-users).	20% of the Medicare-approved amount after the annual Part B deductible.
Bone Mass Measurements: Varies with your health status.	Certain Medicare beneficiaries at risk for losing bone mass.	20% of the Medicare-approved amount after the annual Part B deductible.
Vaccinations: Flu Shot: Once per year. Pneumococcal Vaccination: One may be all you ever need-ask your doctor. Hepatitis B Vaccination: If you are at high or intermediate risk for hepatitis.	All Medicare beneficiaries.	No coinsurance and no Part B deductible for flu or pneumococcal vaccinations. For Hepatitis B vaccination, 20% of the Medicare-approved amount after the annual Part B deductible.

What Are the Gaps In the Original Medicare Plan?

Gaps in the Original Medicare Plan fall into 3 categories:

Categories	Examples of Gaps
What you pay (costs for Medicare covered services)	■ Part A deductible for each benefit period* ■ Part B deductible of $100 per year ■ 20% coinsurance for most covered services
What is partially covered (costs for partially covered services and benefits)	■ Home health care that does not meet certain required conditions ■ First three pints of blood ■ All costs for skilled nursing facility care after day 100 in the benefit period*
What is not covered (costs for non-covered services)	■ Outpatient prescription drugs ■ Eyeglasses ■ Hearing Aids ■ Routine Physical Exams ■ Emergency Care Outside the U.S. ■ Custodial Care**

* Benefit Period: A way to measure your use of hospital and skilled nursing facility services covered by Medicare. A benefit period begins the day you go to a hospital or skilled nursing facility. It ends after you haven't received hospital or skilled nursing care for 60 days in a row (see page 55).

** NOTE: It is important to remember that purely custodial care (the type of care most people in nursing homes need) is not covered by Medicare or most Medigap policies. The only nursing home care that Medicare covers is skilled nursing care that is provided in a Medicare-certified skilled nursing facility typically needed after a serious illness or hospital stay.

Original Medicare Plan:
The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan.

Medigap:
A Medicare supplement insurance policy that is sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. There are 10 standardized policies, labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.

Gaps:
The costs or services that are not covered under the Original Medicare Plan like deductibles, prescription drugs, and coinsurance.

For more information on these Medicare health plans, see Appendix, page 53 ▶

See chart on page 14 for a summary of Medigap policy benefits.

Purchasing Medigap Insurance

If you choose the Original Medicare Plan rather than one of the other Medicare health plans, you may decide that you need more coverage than the Original Medicare Plan provides. Medigap policies only work with the Original Medicare Plan. Many private insurance companies sell Medigap policies for the specific purpose of filling the "gaps" in Original Medicare Plan coverage. These policies must be clearly identified as Medigap policies and must provide specific benefits that help fill in gaps in your Original Medicare Plan coverage. Similar coverage may also be available to retirees through an employer or union health coverage. Other types of insurance may also be available to you to help with out-of-pocket health care costs, but they are not Medigap policies (see page 35).

In all States except Minnesota, Massachusetts, and Wisconsin, federal law limits the Medigap policies that companies may offer to standard supplemental plans. These 10 plans must be labeled with the letters A through J to make it simple to compare plans. State law may limit the types of Medigap policies that are actually sold in your State.

You do not need to buy a Medigap policy if you are enrolled in a:

- Medicare Managed Care Plan
- Private Fee-For-Service Plan
- Medicare Medical Savings Account Plan
- Religious Fraternal Benefit Plan

In fact, it may be illegal for anyone to sell you a Medigap policy if they know you are enrolled in one of these Medicare health plans.

What Medigap Covers

Medigap policies pay most, if not all, of the Original Medicare Plan coinsurance amounts and may provide coverage for the Original Medicare Plan deductibles. Some of the 10 standardized plans pay for services not covered by Medicare such as outpatient prescription drugs, preventive screening, and emergency medical care while traveling outside the United States. Some Medigap policies cover health care provider charges in excess of Medicare's approved amount, and for some care in your home. Benefits for each of the 10 standardized plans are described on pages 16-19.

When describing the benefits of each of the Medigap policies, insurance companies must use the same format, language, and definitions. They also are required to use a uniform chart and outline of coverage to summarize the benefits in each plan (see pages 16-19). These requirements make it easier for you to compare policies. As you shop for a Medigap policy, keep in mind that each company's benefits are alike, so they are competing on service, reliability, and price. Compare benefits and premiums and be satisfied that the insurance company is honest and reliable before buying.

Besides the benefits in standardized plans, federal law permits States to allow an insurer to add "new and innovative benefits" to a standardized plan. Check with your insurance company to find out whether these benefits are available.

What Are Your Medigap Options?

Standardized Medigap Plans ▶

The 10 standardized policies are detailed beginning on page 16. They are called "A" through "J". Plan A is the "basic" benefit package. Each of the other 9 plans includes the basic Plan A package, plus a different combination of additional benefits. Plan J provides the most coverage of all the plans. The plans cover specific costs either not covered or not fully covered by Medicare. Insurance companies cannot change the combination of benefits or the letter names of any of the policies, although a company may add a name for each policy.

Medicare SELECT ▶

Medicare SELECT is a type of standardized Medigap insurance policy. If you buy a Medicare SELECT policy, you are buying one of the 10 standardized Medigap plans. The only difference between Medicare SELECT and Standardized Medigap insurance is that each insurance company has specific hospitals, and in some cases specific doctors, that you must use, except in an emergency, to be eligible for full supplemental insurance benefits. Medicare SELECT policies generally have lower premiums because of this requirement.

When you go to the Medicare SELECT "preferred providers," Medicare pays its share of the approved charges and the insurance company is responsible for all supplemental benefits in the Medicare SELECT policy. In general, Medicare SELECT policies are not required to pay any benefits if you do not use a preferred provider for non-emergency services. Medicare, however, will still pay its share of approved charges no matter what provider you choose.

Chart of Ten Standardized Medigap Policies

Medigap can only be sold in 10 standardized plans. This chart shows the benefits included in each plan. Every company offers Plan A. Companies may have some, all, or none of the other plans. Some plans may not be available in your State. More detailed information about the benefits in this chart are found on pages 16-19.

Basic Benefits: Included in All Plans.

- Hospitalization: Part A coinsurance plus coverage for 365 additional days during your lifetime after Medicare benefits end.
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).
- Blood: First 3 pints of blood each year.

MEDIGAP BENEFITS	A	B	C	D	E	F*	G	H	I	J*
Basic Benefits	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A: Inpatient Hospital Deductible		✓	✓	✓	✓	✓	✓	✓	✓	✓
Part A: Skilled-Nursing Facility Co-Insurance			✓	✓	✓	✓	✓	✓	✓	✓
Part B: Deductible			✓			✓				✓
Foreign Travel Emergency			✓	✓	✓	✓	✓	✓	✓	✓
At-Home Recovery				✓			✓		✓	✓
Part B: Excess Charges						100%	80%		100%	100%
Preventive Care					✓					✓
Prescription Drugs (see page 15)								Basic ✓ coverage	Basic ✓ coverage	Extended ✓ coverage

* Plans F and J also have a high deductible option (see page 15).

Chart used with permission from the United Seniors Health Cooperative.

Does Medigap Cover Prescription Drugs?

Yes. Plans H and I offer the basic prescription drug benefit. Plan J offers the extended prescription drug benefit.

Basic Prescription Drug Coverage ▶

After you pay the $250 per year deductible, the plan pays 50% of the costs of your prescription drugs up to a maximum of **$1,250** per year.

Extended Prescription Drug Coverage ▶

After you pay the $250 per year deductible, the plan pays 50% of the costs of your prescription drugs up to a maximum of **$3,000** per year.

What Is A "High Deductible Option" And How Does It Affect Your Costs?

High Deductible Option ▶

Insurance companies may offer a "high deductible option" on Plans F and J. If you choose this option, you must pay $1,500 out-of-pocket per year before the plan pays anything.

Insurance policies with a high deductible option generally cost less than those with lower deductibles. Your out-of-pocket costs for services may be higher if you need to see your doctor or go to the hospital.

Remember, with Plans F and J, there are additional deductibles that must be met including a separate prescription drug deductible of $250 per year for Plan J and a separate foreign travel emergency deductible of $250 per year for Plans F and J.

Is There Any Other Important Information I Need To Know?

Other Important Information On Purchasing A Medigap Policy ▶

There are many individual situations involving health coverage changes (like losing Medicare health plan coverage or employer coverage) that can affect what Medigap policies you can buy and when. See pages 30-33 for information on protections and guarantees for these special situations.

Standardized Medigap Plans

Following is a list of the 10 standardized plans and the benefits provided by each:

Plan A ▶

Plan A has these basic benefits:

- Coverage for the Part A coinsurance amount ($192 per day, in 1999) for days 61 through 90 of a hospital stay in each Medicare benefit period.
- Coverage for the Part A coinsurance amount for days 91-150 of a hospital stay ($384 per day, in 1999) for each of Medicare's 60 lifetime reserve days that may only be used once.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during your lifetime. You may be responsible for payment when Medigap hospital benefits are exhausted.
- Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year unless this blood is replaced.
- Coverage for the coinsurance amount for Part B services (generally 20% of Medicare-approved amount) after $100 annual deductible is met.

Basic Benefits:
Benefits provided in Medigap Plan A. They are also included in all the other Medigap plans.

Plan B ▶

Plan B has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).

Plan C ▶

Plan C has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- Coverage for the Medicare Part B deductible ($100 per calendar year, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

Plan D ▶

Plan D has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living (like bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury, or surgery.

Plan E ▶

Plan E has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for preventive medical care. The preventive medical care benefit pays up to $120 per year for things like a physical examination, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test.

Plan F ▶

High deductible option permitted (see page 15)

Excess Charge (Medigap):
The difference between a doctor's or other healthcare provider's actual charge (up to the amount of charge limitation set by Medicare or the state) and the Medicare-approved payment amount.

Plan G ▶

Plan H ▶

Plan F has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- Coverage for the Medicare Part B deductible ($100 per calendar year, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for 100% of Medicare Part Bexcess charges .

Plan G has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living (like bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury, or surgery.
- Coverage for 80% of Medicare Part Bexcess charges .

Plan H has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for 50% of the cost of prescription drugs up to a maximum of $1,250 per year after you meet a $250 deductible per year (basic prescription drug benefit).

Plan I ▶

Excess Charge (Medigap):
The difference between a doctor's or other healthcare provider's actual charge (up to the amount of charge limitation set by Medicare or the state) and the Medicare-approved payment amount.

Plan I has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living (like bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury, or surgery.
- Coverage for 100% of Medicare Part Bexcess charges .
- Coverage for 50% of the cost of prescription drugs up to a maximum of $1,250 per year after you meet a $250 deductible per year (basic prescription drug benefit).

Plan J ▶

High deductible option permitted (see page 15)

Excess Charge (Medigap):
The difference between a doctor's or other healthcare provider's actual charge (up to the amount of charge limitation set by Medicare or the state) and the Medicare-approved payment amount.

Plan J has these benefits:

- All the basic benefits of Plan A plus:
- Coverage for the Medicare Part A inpatient hospital deductible ($768 per benefit period, in 1999).
- Coverage for the skilled nursing facility coinsurance amount ($96.00 per day, for days 21-100 per benefit period, in 1999).
- Coverage for the Medicare Part B deductible ($100 per calendar year, in 1999).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at-home recovery. The at-home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living (like bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury, or surgery.
- Coverage for 100% of Medicare Part Bexcess charges .
- Coverage for preventive medical care. The preventive medical care benefit pays up to $120 per year for things like a physical examination, serum cholesterol screening, hearing test, diabetes screening, and thyroid function test.
- Coverage for 50% of the costs of prescription drugs up to a maximum of $3,000 per year after you meet a $250 per year deductible ("extended" prescription drug benefit).

Shopping For A Medigap Policy

When shopping for a Medigap policy, think about:

- Medigap Premiums: There are big differences in the premiums insurance companies charge for exactly the same coverage. When comparing premiums, be sure you are comparing identical Medigap plans. Insurance companies use different methods to calculate premiums:
  - Age Rating: Generally this means that the older you are, the more a Medigap policy costs.
  - No Age Rating (also known as community rating): Generally, this means that a company charges one premium for all policyholders regardless of age.

Suppose you buy a Medigap policy at age 65. The following chart shows an example of what happens to your Medigap policy premiums as you get older using each of these types of ratings:

Rating Method	Premium at Age 65	Premium at Age 75	Premium at Age 85
Age Rating	$70	$90	$130
No Age Rating (Community Rating)	$90	$90	$90

- There are actually two different ways companies can age rate: "Issue age" versus "Attained age" rating. In general, if you are buying a Medigap policy which uses age rating, policies with issue age rating will be slightly better in price than attained age policies.

  Issue Age: The way that companies calculate Medigap premiums based on how old you are when you bought the policy. Premiums may change due to inflation, but will not be changed due to changes in your age.

  Attained Age: Premiums will increase as you grow older.

Remember, all premiums may go up each year because of inflation.

- Medical Underwriting: During open enrollment, and with special Medigap protections (see pages 21, 23 and 30-33), companies cannot use medical underwriting or refuse to write you a policy. During other times, companies can refuse to issue a Medigap policy based on your health conditions and companies may medically underwrite any Medigap policy. Medical underwriting is the process that a company uses to determine whether or not to accept your application for insurance, and how much to charge you for that insurance. It usually involves answering medical questions on an application. Some companies may require a review of your medical records.

- Other Features: For some policies, you must belong to a certain group or organization to purchase a policy sold by the group or organization. In addition, some companies may offer innovative benefits or discounts to couples or nonsmokers.

Medigap for People Age 65 and Older

Open Enrollment:
A period of 6 months that starts when you are both 65 or older and enrolled in Part B. During this time, you have the right to buy the Medigap policy of your choice regardless of any health problems you may have.

Pre-existing Condition:
Health problems that required medical treatment within the 6 months before the date that the policy went into effect.

Exclusion Period:
A period of time of up to 6 months when an insurer can delay coverage of a pre-existing condition.

Creditable Coverage:
Any previous health coverage that can be credited toward pre-existing condition restrictions.

Open Enrollment Guarantees Your Right to Medigap Coverage. For a period of 6 months from the date you are both age 65 or older and enrolled in Medicare Part B, you have a right to buy the Medigap policy of your choice, regardless of any health problems you may have.

During this 6-month open enrollment period, you can buy any Medigap policy sold by a company doing Medigap business in your State. The company cannot deny you or use your medical history, health status, or claims experience to change the issuance or effectiveness, or discriminate in the pricing of a Medigap policy. The company can use pre-existing condition restrictions or exclusion periods for up to 6 months. However, insurance companies can't use exclusion periods for pre-existing conditions if you had at least 6 months of creditable coverage. Any new health problem, however, would be covered immediately.

Creditable coverage is health coverage under:

- a group health plan (such as an employer plan);
- health insurance coverage;
- Part A or Part B of Medicare;
- Medicaid;
- a medical program of the Indian Health Service or tribal organization;
- a State health benefits risk pool;
- TRICARE (the health care program for military dependents and retirees, formerly called Champus);
- the Federal Employees Health Benefit Plan;
- a public health plan; or
- a health plan under the Peace Corps Act.

You can't have any breaks in health coverage that are longer than 63 calendar days for this coverage to be credited toward pre-existing conditions restrictions.

Example (Open Enrollment) ▶

John is 68 and has heart disease. He has just enrolled in Medicare Part B. His effective date is November 4, 1998. John has until May 4, 1999 to buy his Medigap policy without his heart disease affecting the cost or type of policy he can choose. After May 4, 1999, John will not have this guarantee.

Your Medicare card shows the dates that your Part A and/or Part B coverage started. If you are 65 or older, you can figure out whether you are in your Medigap open enrollment period by adding 6 months to the effective date of your Part B coverage. If the date is in the future, you are eligible for open enrollment. If the date is in the past, you are generally not eligible. (If you were entitled to Medicare before age 65, see page 23.)

Example (Creditable Coverage) ▶

John is 68 and has heart disease. He has been enrolled in Medicare Part B since November 4, 1998. On March 4, 1999, John buys the Medigap policy of his choice from Company X. Company X is using a 6-month exclusion period for John's pre-existing heart disease condition. However, Company X is giving John 4 months of credit towards the 6-month exclusion period for the time he was enrolled in Medicare Part B before he bought a Medigap policy. John only has 2 months left on the exclusion period for his pre-existing heart disease condition. During these 2 months, Company X will not pay any costs for John's heart disease condition.

Important

Medigap Open Enrollment Issues ▶

Persons Over Age 65 Who Are Working ▶

If you are working, or are the spouse of a working person over age 65 and are covered under an employer or union group health plan when you become eligible for Part B at age 65, carefully consider your options. **Once you enroll in Part B, the 6-month Medigap open enrollment period starts and cannot be extended or repeated**.

Employer Or Union Health Coverage ▶

If you are working, and are covered under an employer or union group health plan that pays most of your medical bills, you will not need a Medigap plan until you are no longer covered under the employer or union plan. You may, therefore, want to wait to take Part B until you are ready to make the best use of your Medigap open enrollment period. If you enroll in Medicare Part B as a supplement to your employer or union plan while it is theprimary payer , you will start your Medigap open enrollment period when it is of little use to you. Once you have started

Primary Payer:
The insurance company which pays first on a claim for medical care.

Medical Underwriting:
The process that a company uses to determine whether or not to accept your application for insurance and how much to charge you for that insurance.

your Medigap open enrollment period at age 65, it cannot be extended or repeated. If you drop Part B and re-enroll during a special enrollment period after you are no longer covered under your employer or union health plan, you will not get another Medigap open enrollment period.

Waiting to take Part B so you can make the best use of the Medigap open enrollment period may not be important if you are in good health. In this case, the company would use medical underwriting. The company would probably accept your application for insurance, and charge you a reasonable amount for the insurance. However, this is not a guarantee.

Medigap for People Under Age 65

Medigap Open Enrollment and Persons with Disabilities or ESRD:

- Under federal law, if you become eligible for Part B benefits before age 65 because of a disability or ESRD (permanent kidney failure), you are guaranteed the Medigap policy of your choice when you reach age 65. During the first 6 months you are age 65 and enrolled in Part B, you can buy the Medigap policy of your choice regardless of whether you had enrolled in Part B before you were age 65.

- During the 6 months after you turn 65, you cannot be refused a Medigap policy because of your disability or for other health reasons. This includes Medigap policies that cover outpatient drugs, if they are available. Since Medicare counts as "creditable coverage," you will not have to wait for coverage of pre-existing conditions unless you have been covered under Medicare for less than 6 months.

Several States go beyond federal law and require at least a limited Medigap open enrollment period for Part B beneficiaries under age 65. Check to see whether your State does. Remember, you will be given an open enrollment opportunity when you turn age 65, even if you had an earlier open enrollment under state law.

If you did not buy your Medigap insurance during the open enrollment period, and are still in good health, you may be able to get the policy you want at a good price.

Also, if your Medicare health plan coverage ends or is lost, you may have the special opportunity to purchase a Medigap policy (see page 31).

If you are denied Medigap coverage, you should contact your state insurance department (see page 47).

Tips On Shopping For A Medigap Policy

Whether you need more health insurance is a decision that only you can make. If you decide to buy more insurance, shop carefully. Look for a Medigap policy that you can afford that offers the benefits you think you need most. Here are some helpful tips for you to keep in mind when shopping for health insurance.

Shop Carefully Before You Buy ▶

Medigap policies differ in coverage and cost. Companies differ in the way they price Medigap policies based on age and health status when purchased outside of the open enrollment period. Companies also differ in customer service. Contact different companies and compare the premiums before you buy.

Don't Buy More Policies Than You Need ▶

Medigap policies are designed so that you generally do not need other similar coverage. Duplicate coverage can be expensive and is generally unnecessary. It is illegal for an insurance company to sell you a second Medigap policy unless you state in writing that you intend to cancel the first Medigap policy after the replacement Medigap policy goes into effect. Anyone who sells you a Medigap policy in violation of the various anti-duplication provisions is subject to criminal and/or civil penalties under federal law. Call the Medicare Hotline at 1-800-638-6833 to report suspected violations.

Consider Your Alternatives ▶

Depending on your health care needs and finances, you may want to consider continuing any employee or retiree health coverage you have at work, joining a Medicare Managed Care Plan, or buying a Medigap policy. Further, you may want to consider buying a long-term care insurance policy in addition to Medigap, group coverage, or a Medicare Managed Care Plan.

Check For Pre-Existing Condition Exclusions ▶

In checking a policy before you buy, you should find out whether it limits or excludes coverage forpre-existing conditions . If you have a health problem and the policy limits or excludes coverage for pre-existing health conditions, the insurer might not cover your costs for any care related to that health problem. Medigap policies, however, are required to cover pre-existing conditions after the policy has been in effect for 6 months. Some insurance companies may have shorter waiting periods before covering a pre-existing condition. Other insurance companies may not have any pre-existing condition limitations. If you buy a policy during your open enrollment period, the insurance company must reduce the pre-existing condition exclusion by the amount of creditable coverage (see page 21).

Pre-existing Condition:
Health problems that required medical treatment within the 6 months before the date that the policy went into effect.

Tips On Shopping For A Medigap Policy continued:

Be Careful Of Replacing Existing Coverage ▶

Make sure you have a good reason for switching from one Medigap policy to another—you should only switch for different benefits, better service, or a more affordable price. On the other hand, don't keep inadequate policies simply because you have had them for a long time. If you decide to replace your Medigap policy, you must be given credit for the time you had the old policy toward pre-existing conditions restrictions under the new policy. You must also sign a statement that you plan to cancel the first policy. Do not cancel the first policy until you are sure that you want to keep the new policy. You have a free look period, which is usually 30 days, to decide whether or not to keep the new Medigap policy.

Policy Delivery Or Refunds Should Be Prompt ▶

The insurance company should deliver a policy within 30 days. If it does not, call the company and ask them to put the reason for the delay in writing. If 60 days go by without an answer, call your state insurance department (see page 47).

Prohibited Marketing Practices ▶

It is unlawful for an insurance company or agent to use high pressure tactics to force or frighten you into buying a Medigap policy, or to make false or misleading comparisons to get you to switch from one company or policy to another. Deceptive "cold lead" advertising is also prohibited. This tactic involves mailings to people who might be interested in buying insurance. If you fill in and return the card enclosed in the mailing, the card may be sold to an insurance agent who will try to sell you a policy.

Medigap Policies Are Neither Sold Nor Serviced By The State Or Federal Government ▶

State insurance departments approve Medigap policies sold by private insurance companies but approval only means the company and Medigap policy meet requirements of state law. Do not believe statements that insurance to supplement Medicare is a government-sponsored program. If anyone tells you that they are from the government and later tries to sell you a Medigap policy, report that person to your state insurance department or federal authorities. This type of misrepresentation is illegal. It is also illegal for a company or agent to claim that a Medigap policy has been approved for sale in any State in which it has not received state approval or to use false means to gain approval.

Tips On Shopping For A Medigap Policy continued:

Know With Whom You Are Dealing ▶

An insurance company must meet certain qualifications to do business in your State. You should check with your state insurance department to make sure that any company you are considering is licensed in your State. This is for your protection. Agents must also be licensed by your State and may be required by the State to carry proof of licensure showing their name and the company they represent. If the agent cannot verify that he or she is licensed, do not buy a policy from that person. A business card is not a license.

Keep Agents' And/Or Companies' Names, Addresses, And Telephone Numbers ▶

Write down the agents' and/or companies' names, addresses, and telephone numbers or ask for a business card that has this information.

Take Your Time ▶

Do not be pressured into buying a Medigap policy. Good sales people will not rush you. If you are not certain whether a Medigap policy is what you need, ask the salesperson to explain it to you with a friend or family member present. Keep in mind, however, that if you are within your 6-month open enrollment period (see page 21) or qualify for special protections (see pages 30-33), you will have a limited time period in which to buy the Medigap policy of your choice without special conditions being imposed. Once this 6-month open enrollment or special protection period ends, the Medigap policies available to you may be limited, especially if you have a pre-existing health condition.

If You Decide To Buy, Complete The Application Carefully ▶

Do not believe an insurance agent who says your medical history on an application is not important. Some companies ask for detailed medical information. If you leave out any of the medical information requested, coverage could be refused for a period of time for any medical condition you did not report. The company also could deny a claim and/or cancel your Medigap policy for treatment of a condition you did not report .

Look For An Outline Of Coverage ▶

You must be given a clearly worded summary of the policy...READ IT CAREFULLY.

Do Not Pay Cash ▶

Pay by check, money order, or bank draft made payable to the insurance company, not to the agent or anyone else. Get a receipt with the insurance company's name, address, and telephone number for your records.

Tips On Shopping For A Medigap Policy continued:

Beware Of Non-Standard Plans ▶

It is illegal for anyone to sell you a policy and call it a Medigap policy if it does not match Medigap standardization requirements. A "retainer agreement" that a doctor offers you to provide certain non-Medicare-covered services and waive the Medicare coinsurance and deductible amounts, may be illegal. If a doctor refuses to see you as a Medicare patient unless you pay him or her an annual fee and sign one of these retainer agreements, you should call the Medicare Hotline at 1-800-638-6833.

How to File Claims

Information on how to file a claim is usually included with your Medigap policy. If you have questions, call your Medigap insurance company to find out how claims are filed, and how to get reimbursed for your out-of-pocket medical expenses.

Carrier Filing Of Medigap Claims ▶

Under most circumstances, when you get medical services that are covered by both Medicare and your Medigap insurance, you may not have to file a separate claim with your Medigap insurer.

By law, the Medicare carrier that processes Medicare Part B claims for your area must send your claims to the Medigap insurance company. The Medigap insurance company will make payments directly to your doctor or provider when the following three conditions are met:

- Your doctor or supplier has signed a participation agreement with Medicare to accept assignment of Medicare claims for all patients who are Medicare beneficiaries;
- Your policy is a Medigap policy; and
- You tell your doctor's office to put on the Medicare claim form that you wish payment of Medigap benefits to be made to the participating doctor or supplier. Your doctor will put your Medigap policy number and company on the Medicare claim form. You will need to sign the claim form.

Assignment:
In the Original Medicare Plan, a process through which a doctor or supplier agrees to accept the amount Medicare approves as payment in full. (You must pay any coinsurance amount.)

When these conditions are met, the Medicare carrier will process the Medicare claim, send the claim to the Medigap insurance company, and generally send you an Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN). Your Medigap insurance company will pay benefits directly to your doctor or other provider and send you a notice that it has done so. If you don't get this notice, you can request it from your Medigap insurance company.

If the Medigap insurance company refuses to pay the doctor directly when the above three conditions are met, you should report this to your state insurance department. For more information on Medigap claim filing by the carrier, contact your Medicare carrier (see pages 51-52).

In most cases, Medigap insurance companies have a special agreement with Medicare under which claims are sent directly to the insurance company, even if the doctor does not accept assignment (also called a participation agreement).

Important Information You Should Know Before Signing A Private Contract ▶

Will Medicare And Medigap Pay If I Have A Private Contract?

Medicare and Medigap will **not** pay if you have a private contract with your doctor or other practitioner to receive services that would otherwise be covered by Medicare.

A private contract is a contract between a Medicare beneficiary and a doctor or other practitioner who has decided not to provide services through the Medicare program. This doctor can not bill Medicare for any service or supplies given to any Medicare beneficiary for at least 2 years.

Under a private contract:

- No Medicare payment will be made for the services you receive.
- You will have to pay whatever the doctor or practitioner charges you (the limiting charge will not apply).
- Medicare Managed Care Plans will not pay for these services.
- No claim should be submitted, and Medicare will not pay if one is.
- If you have a Medigap Policy, it will not pay anything for this service. Contact your insurance company before you receive the service.
- Many other insurance plans will not pay for the service either.

Limiting Charge:
The maximum amount doctors and other health care providers who don't accept assignment can charge you for a covered service. The limit is 15% over Medicare's approved payment amount.

The private contract only applies to the services provided by the doctor who asked you to sign it. You cannot be asked to sign a private contract when you are facing an emergency or urgent health situation. You may want to talk with someone in your State Health Insurance Assistance Program before signing a private contract (see page 48).

You may choose to pay on your own for services the Original Medicare Plan doesn't cover. In this case, your doctor does not have to stop providing services through Medicare or ask you to sign a private contract. You are always free to get non-covered services on your own if you choose to pay for the service yourself.

Protections and Guarantees

Medigap Protection If You Enroll In Medicare SELECT Or Join A Medicare Health Plan Other Than The Original Medicare Plan ▶

You may be able to return to a Medigap policy that you dropped to enroll in a Medicare SELECT policy or a Medicare health plan other than the Original Medicare Plan (for example, a Medicare Managed Care Plan). However (1) this must be the first time that you enrolled in a Medicare health plan or Medicare SELECT policy; (2) you must leave the Medicare health plan or Medicare SELECT policy within one year after joining; and (3) after leaving your Medicare health plan or Medicare SELECT policy, you must apply for your former Medigap policy within 63 calendar days after the health plan coverage ends if your previous Medigap insurance company still sells the policy in your State.

If your previous Medigap policy is not available, you are guaranteed the right to purchase Medigap policies "A", "B", "C", or "F" from any insurance company which sells these plans in your State if you apply within 63 calendar days after coverage ends. In these cases, the insurance company may not:

- deny or condition the sale of the policy or discriminate in the pricing of the policy because of your health status, prior history of claims experience, receipt of health care or medical condition, or
- impose an exclusion period for any pre-existing condition.

Example ▶

On December 5, 1998, Sam enrolled in a Medicare Managed Care Plan for the first time. Prior to December 5th, Sam had Medigap policy "Plan C". Six months after enrolling in the Medicare Managed Care Plan, Sam decides that he wants to return to his "Plan C" Medigap policy. Sam leaves the Medicare Managed Care Plan on May 12, 1999. For Sam to return to his "Plan C" Medigap policy, he must make sure that his Medigap insurance company still sells this policy, and apply for it by July 14, 1999 (within 63 calendar days).

Medicare SELECT ▶

The protections and guarantees described above may apply when you lose or drop coverage under a Medicare SELECT policy. All rights to buy a Medigap policy under these protections and guarantees include the right to buy a Medicare SELECT policy since it is a type of Medigap policy. If you currently have a Medicare SELECT policy, you also have additional rights for as long as you have this policy that might provide you with better options for changing your insurance coverage. After you have had the Medicare SELECT policy for at least 6 months, you can switch to a regular Medigap policy sold by the same company, as long as the new policy has equal, or less coverage than the Medicare SELECT policy.

Another Option ▶

Even if you do not meet these conditions, your Medigap insurance company may still allow you to buy a similar policy, especially if you are in good health.

Medigap Protection When Other Types Of Health Coverage End Or Are Lost ▶

If you lose health coverage under certain circumstances, you will have a guaranteed right to purchase Medigap policies "A", "B", "C", or "F" that are sold in your State, as long as you apply within 63 calendar days of losing your other health coverage. The circumstances include the following:

- Your Medicare Managed Care Plan, Medicare MSA Plan, or Private Fee-For-Service Plan terminates its participation in Medicare or stops providing care in your area.
- You move outside the plan's service area.
- You leave the plan because it failed to meet its contract obligations to you.
- You were in an employer group health plan that supplemented or was secondary payer to Medicare and the plan terminates coverage (see page 37).
- Your supplemental insurance company terminates your Medigap policy or Medicare SELECT policy (and you're not at fault).

You will be given credit for any previous health coverage you had to meet the pre-existing condition requirement.

Does This Protection Cover Me If I Am Under Age 65 And Eligible For Medicare Because Of A Disability Or ESRD?

If you live in a State where Medigap policies are sold to people under age 65 who are eligible for Medicare due to disability or ESRD, you may have the same protection as those over age 65 if your health insurance ends or is lost. If Medigap insurance companies in your State sell Medigap policies "A", "B", "C", or "F" to people under age 65, they must also make these policies available to you when your health coverage ends or is lost. Call your State Health Insurance Assistance Program for more information (see page 48).

Are There Any Important Records I Should Keep If My Health Coverage Ends Or Is Lost?

Keep a copy of the termination letter that is mailed to you if your plan stops providing care, a dated copy of your Medigap application, and any Medigap company denial letters you receive.

Caution

While you can apply for a Medigap policy before your health coverage ends or is lost, the protections described here will NOT be guaranteed if you voluntarily disenroll or switch before the health coverage ends or is lost. You should keep a copy of your plan's termination letter in case you have to prove that you lost coverage in a situation described above.

Is There Any Other Time When You May Be Guaranteed Issuance Of A Medigap Policy?

You are guaranteed issuance of ANY Medigap policy if:

- when you first became eligible for Medicare at age 65, you enrolled in a Medicare health plan other than the Original Medicare Plan, and
- you then disenroll from that plan within 12 months of the effective date of your enrollment.

You must apply for the Medigap policy within 63 calendar days of disenrolling from the health plan. If you are denied Medigap coverage, you should contact your state insurance department (see page 47).

Summary Of Protections and Guarantees:

Enrollment Situation	Enrollment Options
You lost your health coverage because : ■ your Medicare Managed Care Plan, Medicare MSA plan, or a Private Fee-for-Service Plan terminated its Medicare participation or stopped providing care in your area; or ■ you moved outside the plan's service area; or ■ you left the plan because it failed to meet its contract obligations to you; or ■ you were in an employer group health plan that terminated coverage and was a secondary payer to Medicare; or ■ your Medigap insurance company coverage terminated due to the insurance company's insolvency (and your State does not require continuation or conversion of coverage under the policy); or ■ you leave the plan because it failed to meet its contract obligations to you.	If you are age 65 or over, you must be allowed to purchase Medigap policies "A", "B", "C", or "F" that are sold in your State, as long as you apply within 63 calendar days of losing your other health coverage. In some States, if you are under age 65 and entitled to Medicare due to disability or ESRD you must be allowed to purchase any Medigap policy that is otherwise available to beneficiaries under age 65. In either case, the insurance company cannot deny you the policy, place conditions on the policy such as a waiting period, apply a pre-existing condition exclusion, or discriminate in the price of the policy based on your health status.

Summary Of Protections and Guarantees continued:

Enrollment Situation	Enrollment Options
You dropped your Medigap policy to enroll in a Medicare health plan like a Medicare Managed Care Plan or Medicare SELECT policy and (1) this was the first time that you enrolled in a Medicare health plan or Medicare SELECT policy; (2) you left the Medicare health plan or Medicare SELECT policy within one year after joining; and (3) after leaving your Medicare health plan or Medicare SELECT policy, you applied for your former Medigap policy within 63 calendar days after your coverage terminated.	You must be allowed to return to your original Medigap policy, if it is still available from the same insurance company, and, if it is no longer available, you must be allowed to purchase Medigap policies "A", "B", "C", or "F", within 63 calendar days under the same conditions described above.
You enrolled in a Medicare health plan other than the Original Medicare Plan when you first became eligible for Medicare at age 65 and you disenrolled from the Medicare health plan within one year after joining; and you applied for a Medigap policy within 63 calendar days after your coverage ended under the Medicare health plan.	You must be allowed to purchase any Medigap policy sold in your State, with no conditions such as a waiting period and no pre-exisiting condition exclusion, and without discrimination in the price of the policy based on your health status, within 63 calendar days after your health plan coverage ends.

All rights to buy Medigap policies under these protections and guarantees include Medicare SELECT policies since they are a type of Medigap policy.

Switching Medigap Policies

Many Federal requirements do not apply to Medigap policies sold before 1992, when Medigap was standardized. There is generally no requirement that you switch to one of the standardized plans if you have an older Medigap policy. However, you may be required to switch if your older policy was not guaranteed renewable and the company discontinues the type of Medigap policy you have. Even if you are not required to convert an older Medigap policy, you may want to consider switching to one of the standardized Medigap policies if you have an older Medigap policy and you want to change for better rates and/or service.

If you do switch policies, you will not be allowed to go back to the old or pre-standardized Medigap policy. If you decide to switch to a standardized Medigap policy, you may face medical underwriting. Before switching, compare benefits and premiums. Some of the older Medigap policies may provide better coverage, especially for prescription drugs and extended skilled nursing care. On the other hand, older Medigap policies, which cannot be sold to new applicants, may have bigger premium increases than newer standardized Medigap policies, which can enroll new applicants.

Medical Underwriting: The process that a company uses to determine whether or not to accept your application for insurance, and how much to charge you for that insurance.

If you have had a Medigap policy for at least 6 months and you decide to switch, the new Medigap policy generally cannot impose an exclusion period for a pre-existing condition. If, however, a benefit is included in the new Medigap policy that was not in the old Medigap policy, a waiting period of up to 6 months may be applied to that particular benefit.

You do not need more than one Medigap policy. If you already have a Medigap policy, you must sign a statement before you buy another one saying that you plan to replace your current Medigap policy and will not keep both Medigap policies. However, do not cancel the old Medigap policy until the new one is in force and the pre-existing conditionperiod is over, and you have decided to keep the new Medigap policy.

Pre-existing Condition: Health problems that require medical treatment within the 6 months before the date that the policy went into effect.

Guaranteed Renewable ▶

All standardized Medigap policies are guaranteed renewable. Your insurance company must allow you to renew your Medigap policy unless you do not pay the premiums. Companies may refuse to renew older Medigap policies (sold before 1992) on an individual basis. These older Medigap policies provide the least permanent coverage.

Example ▶

In 1990, Mary bought a Medigap policy from Company A. The Medigap policy Mary bought was not guaranteed renewable. Company A is discontinuing the type of Medigap policy that Mary has. Therefore, Mary must switch to another Medigap policy. Her choices include any one of the ten standardized Medigap policies A through J that are sold in her State.

Group Health Coverage

Group Health Coverage Provided By Employers Or Unions ▶

There are several kinds of coverage that might be called "group" health coverage. Some are offered under group health plans provided by employers or unions for current employees or retirees. Employer plans will generally have better rates than you can get with a policy you buy yourself. Other "group" coverage may be offered to members of an organization or association. Just because you are buying through an association does not mean that you are getting a low rate. Association coverage can be as expensive as, or more costly than, the same coverage under a policy you buy yourself. Be sure you understand the benefits included and then compare prices.

Association Health Coverage ▶

When you reach age 65 you will need to make a decision about Part B (see page 22). You may still have health coverage through your or your spouse's current employer or union membership. If you have this kind of coverage, find out if it can be continued after you retire. Check the price and the benefits, including benefits for your spouse.

Pre-existing Condition:
Health problems that required medical treatment within the 6 months before the date that the policy went into effect.

Group health coverage continued after retirement usually has the advantage of having no waiting periods or exclusions for pre-existing conditions. Coverage is usually based on group premium rates, which may be lower than the premium rates for a policy you buy yourself. One note of caution, however. If you have a spouse under age 65 who was covered under your group health plan, make sure you know what effect your continued coverage will have on his or her insurance protection.

More On Retiree Coverage

Retiree coverage that is not a Medigap policy does not have to follow the rules for Medigap policies, but, under some circumstances, must follow the rules of the Department of Labor. These plans have their own rules and might not fill the gaps in Medicare. They might not pay your medical expenses during any period in which you were eligible for Medicare but did not sign up for it. While retiree coverage may not offer the same benefits as a Medigap policy, it may offer other benefits such as prescription drug coverage and routine dental care. Keep in mind that the retirement coverage provided by your employer or union may have caps or limits on benefits. If you are not sure how your plan works with Medicare, get a copy of the benefits booklet (or look at the Summary Plan Description provided by your employer or union) or call your health plan administrator and ask how the plan pays when you have Medicare.

What Happens If You Drop Employer-Based Coverage?

Caution

If you drop your employer-based group health coverage, you probably won't be able to get it back. Call your health plan administrator for more information.

Other Retiree Health Insurance Options

Retiree Coverage And Medigap ▶

You may buy a Medigap policy even if it duplicates your retiree coverage benefits under a group health plan. The Medigap policy must pay full benefits even if the retiree coverage also pays for the same service. Your retiree coverage may, however, contain a coordination of benefits clause. If it does, it will not pay duplicate benefits. You may want to talk with your State Health Insurance Assistance Program (see page 48) before purchasing a Medigap policy that would duplicate any of your retiree health benefits.

Coordination Of Benefits Clause:

A written statement that tells which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare plan, federal law may decide who pays first.

More Information on Employee And Retiree Coverage

What Health Benefits Must Be Provided If I Am Age 65 Or Older And Still Working?

Employers with 20 or more employees must offer the same benefits, including health benefits under the same conditions, to current employees age 65 and over as they offer to younger employees. If they offer coverage to spouses, they must offer the same coverage to spouses age 65 and over that they offer to spouses under age 65. If your employer and/or employer group health coverage does not follow this rule, you should call the Department of Labor (see page 46).

Sometimes, employee health coverage ends automatically at the end of the calendar year. This could trigger or begin the 63 calendar day period for special Medigap protections and guarantees (see page 30) even before you receive notice from your employer that your coverage has ended. Check with your employer to make sure you understand how your coverage works.

What Happens If You Or Your Spouse Stop Working, And You Are Already Enrolled In Medicare Part B?

You should:

- Notify your Medicare carrier by phone or in writing that you or your spouse's employment situation has changed.
- Give the carrier the name and address of the employer plan, your policy number with the plan, the date coverage stopped, and why.
- When you get health care services, tell the doctor or hospital that Medicare now pays first and should be billed first. Give the date your group health plan coverage stopped.

What Happens If You Or Your Spouse Stop Working, And You Are Not Sure Where To Find The Information You Need To Provide To Your Medicare Carrier?

- Your employer is required by the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to send you a Certificate of Creditable Coverage when your group health coverage ends. All of the information you need to give to the Medicare carrier will be on this certificate. If for some reason your employer does not send you a Certificate of Creditable Coverage, you may ask for one. Certificates are usually provided for free.

Who Pays First

Special Rules For Employees Age 65 Or Over ▶

Secondary Payer:
The insurance company that pays second on a claim for medical care.

If you are age 65 or over, and covered by a group health plan because of current employment or the current employment of a spouse of any age, Medicare is the secondary payer if the employer has 20 or more employees. This means that the plan coverage pays first on your hospital and medical bills. If the plan does not pay all of your expenses, Medicare may pay secondary benefits for Medicare-covered services after the benefits paid by the group health plan.

If the plan denies the claim entirely, Medicare may pay benefits for Medicare-covered services. This requirement applies to those who have group health coverage as an employee, the spouse of an employee, employer, self-employed person, or a business associate of the employer.

Primary Payer:
The insurance company that pays first on a claim for medical care.

You may accept or reject group health plan coverage from your or your spouse's current employer. If you accept the coverage, the plan will be yourprimary payer . If you reject the plan, Medicare will be the primary payer for Medicare-covered health care services that you receive. If you reject the plan coverage, the employer cannot provide you with a plan that pays supplemental benefits for Medicare-covered services or pay for such

coverage in any other way. An employer may, however, offer a plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care, and physical check-ups. If you elect to have Medicare as your primary payer, and you enroll in Medicare Part B, your 6-month Medigap open enrollment period will be triggered (see page 22). To help you decide whether to keep group health plan coverage, talk with your health plan administrator, your state insurance department, or your State Health Insurance Assistance Program (see page 47 or 48).

Special Rules For Disabled Medicare Beneficiaries ▶

Medicare is also the secondary payer for people under age 65 who are entitled to Medicare because of disability and are covered by a large group health plan (LGHP) because of their current employment or the current employment of a family member. A LGHP is a plan of, or contributed to by, an employer or employee organization that covers the employees of at least one employer with 100 or more employees. The secondary payer requirement applies to employers, employees, and members of their families covered by large group health coverage or employer and union sponsored health plans. It also applies to those who have LGHP coverage as a self-employed person, business associate of an employer, or as a family member of one of these people. A LGHP must not treat any of these beneficiaries differently because they are disabled and have Medicare.

Special Rules For Medicare Beneficiaries With End Stage Renal Disease (ESRD) ▶

Medicare is the secondary payer to a group health plan for 30 months for beneficiaries who have Medicare because of ESRD (permanent kidney failure). This applies only to those with ESRD, whether you have plan coverage of your own or as a dependent. The group health plan coverage is the primary payer during this period without regard to the size of the employer-based coverage, the number of employees, or whether the individual or a family member is currently employed.

For more information on ESRD, you may get a copy of *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* from the Health Care Financing Administration by calling the Medicare Hotline at 1-800-638-6833.

COBRA Coverage If You Have Health Plan Coverage Through Your Job Or Your Spouse's Job ▶

Employers with 20 or more employees are usually required to offer a temporary extension of their group health coverage to people who lose their group health plan under a law originally enacted by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). This may apply to you if you lose your job or have your working hours reduced, or, if you are covered under your spouse's plan and your spouse dies or you get divorced. State law may also impose similar requirements on employers with fewer than 20 employees, but you should check with your state insurance department to make sure (see page 47).

COBRA:
This law requires an employer to allow you to remain covered under the employer's group health plan for a certain length of time after losing your job or having your work hours reduced, or after your spouse's death or a divorce. However, you may have to pay both your share and the employer's share of the premium.

COBRA generally lets you stay in your group health plan for 18 months, but you may have to pay both your share and the employer's share of the premium. If the employer has to follow the federal COBRA requirements, coverage under COBRA may end when you enroll in Medicare. If the continuation coverage is required by State law, your rights will depend on what is allowed under the State law. In most situations that trigger your COBRA rights, other than a divorce, you should receive a notice from your health plan administrator. If you don't receive a notice, or if you get divorced, you should contact your health plan administrator as soon as possible.

Know Who Pays If You Have Other Health Insurance

If you...	Condition	Pays first	Pays second
Are age 65+ and covered by a group health plan because you are working or are covered by a group health plan of a working spouse of any age	■ If the employer has less than 20 employees	■ Medicare	■ Group health plan
	■ The employer has 20 or more employees	■ Group health plan	■ Medicare
Are disabled and covered by a large group health plan of a family member who is working	■ The employer has less than 100 employees	■ Medicare	■ Large group health plan
	■ At least one employer covered by the plan has 100 or more employees	■ Large group health plan	■ Medicare
Have End-Stage Renal Disease (permanent kidney failure), and group health plan coverage	■ First 30 months of eligibility or entitlement to Medicare	■ Group health plan	■ Medicare
	■ After 30 months	■ Medicare	■ Group health plan
Have employer retiree plan	■ Not eligible for Medicare	■ Retiree coverage	■ No insurance
	■ Eligible for Medicare	■ Medicare	■ Retiree coverage

Chart modified and used with permission from the Medicare Rights Center, Inc.

If you have Medicare and group health plan coverage from a job or union, you should learn who pays first before you go to the doctor or to a hospital.

Other Federal Health Insurance Options

What Is The PACE Program?

The Programs of All-inclusive Care for the Elderly (PACE) is a program that combines both inpatient and outpatient medical and long-term care services. To be eligible, you must be at least 55 years old, live in the service area of the PACE program, and be certified as eligible for nursing home care by the appropriate state agency. The goal of PACE is to keep you independent, and living in your community as long as possible, and to provide quality care at low cost.

Services include primary care, social work, restorative therapy, specialty and ancillary medical services, and long-term care services, such as transportation, meals, and personal care. They are provided in the PACE Center, at home, and in other inpatient settings such as a hospital.

An interdisciplinary health care team assesses your needs, develops care plans, and provides services for total care needed. If nursing home placement is needed, PACE provides that service and keeps the continuity of care by regular evaluation and monitoring of your health condition.

PACE sites receive Medicare and Medicaid payments for all eligible enrollees. However, PACE sites are only available in certain communities. To find a PACE site near you, or for more information, please contact your state, county, or local medical assistance office - not a federal office (see page 46). You can also look on the Internet atwww.medicare.gov for PACE locations and telephone numbers.

What Is A Federally Qualified Health Center?

Another possible way to lower your health care costs is to go to a Federally Qualified Health Center (FQHC) for the type of care you usually get in a doctor's office. When you use a FQHC, Medicare pays for some health services that are not usually covered like preventive care. FQHCs include community health centers, tribal health clinics, migrant health services, and health centers for the homeless. Any Medicare beneficiary may go to a FQHC for health care services. They are usually found in inner-city and rural areas. FQHC services available to Medicare beneficiaries include:

- Routine physical examinations.
- Screening and diagnostic tests for vision and hearing problems, and other health problems.
- Flu Shots and other similar vaccines.

When you get these services at a FQHC, there is no $100 annual Part B deductible. If other services are provided, such as X-rays, you would be responsible for the usual Part B annual deductible of $100. The usual 20

percent coinsurance for Part B services may be waived in some instances. To find the FQHC closest to you, call the Medicare Hotline at 1-800-638-6833.

How Can Medicaid Help Low-Income Medicare Beneficiaries?

Coverage and eligibility requirements vary from State to State, but most of your health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid recipients may also receive benefits such as nursing home care and outpatient prescription drugs.

Medicaid also has programs that pay some or all of Medicare's premiums and may also pay Medicare deductibles and coinsurance for certain people who are entitled to Medicare and have a low income. You must have Medicare hospital insurance (Part A). If you are not sure if you have Part A, look on your Medicare card (red, white and blue card). It will show "Hospital Insurance (Part A)" on the lower left corner of the card. You can also call your local Social Security Administration office, or call SSA at 1-800-772-1213.

If you have Part A, your income is limited (see below), and your financial resources such as bank accounts, stocks, and bonds are not more than $4,000 for an individual, or $6,000 for a couple, you may qualify for assistance as a Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualifying Individual (QI).

	1999 Monthly Income Limit*		Program Pays
	Individual	Couple	
QMB	$707	$942	Medicare premiums, deductibles, and coinsurance
SLMB	$844	$1,126	Medicare Part B premium
QI-1	$947	$1,265	Medicare Part B premium
QI-2	$1,222	$1,633	A small part of the Medicare Part B premium

If you think you may qualify, contact your state, county, or local medical assistance office - not a federal office (see page 46).

* Slightly higher amounts are allowed in Alaska and Hawaii. Income limits will change slightly in 2000, and new limits will be available by April 1, 2000.

What If I Have A Medigap Policy And Go On Medicaid?

If you are on Medicaid and have a Medigap policy, you may want to consider suspending the Medigap policy rather than dropping it while you are on Medicaid. By suspending the Medigap policy rather than dropping it, you can start it up again without new medical underwriting or pre-existing condition waiting periods. Call your Medigap insurance company to find out how to suspend a policy. You can only suspend a Medigap policy for up to 2 years.

Can Medicaid Help Pay Health Care Costs For Young Children In My Care Who Are Uninsured?

If you have young children in your care who are uninsured, you may be able to get help to pay for their health care costs under your State's Children's Health Insurance Program. You should contact your state, county, or local medical assistance office to get more information on this program (see page 46).

Other Private Health Insurance Options

The following types of policies are generally limited in scope and are not substitutes for Medigap insurance or comprehensive health coverage. Benefits under these policies are not designed to fill gaps in your Medicare coverage.

Hospital Indemnity Insurance ▶

- Hospital indemnity insurance pays a fixed cash amount for each day you are hospitalized up to a certain number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount.

Specified Disease Insurance ▶

- Specified disease insurance, which is not available in some States, provides benefits for only a single disease, such as cancer, or for a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Remember, Medicare and any Medigap policy you have will very likely cover costs associated with any specified diseases you may have.

Long-Term Care Insurance

Long-term care involves a wide variety of services for people with a prolonged or chronic physical illness, disability, or cognitive disorder (such as Alzheimer's disease). Long-term care is not one service, but many different services aimed at helping people with chronic conditions deal with limitations in their ability to function independently. Long-term care differs from medical care in that long-term care helps to assist you in remaining as functionally independent as possible. Long-term care services may include, but are not limited to, help with daily activities at

Long-Term Care Insurance continued:

home, such as bathing or dressing, respite care, home health care, adult day care, and care in a nursing home. Medical care is used to find, treat, and correct medical problems. Medical care services may include blood tests to find a health problem, surgery to remove cancer, a cast to fix a broken bone, or medicine to treat an infection.

What Is Long-Term Care Insurance?

Long-term care insurance may cover some of the many different services that may include help with daily activities at home, or fill some gaps in the coverage that you and/or your spouse may need in the future.

If you are shopping for long-term care insurance, find out which types of nursing homes and long-term care services are covered by the different policies available. For more information about long-term care insurance, ask for a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your state insurance department or the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64105-1925. You may also get a copy of the *Guide to Choosing a Nursing Home* from the Health Care Financing Administration by calling the Medicare Hotline at 1-800-638-6833.

Does Medicare Cover Long-Term Care?

Medicare and most Medigap policies do not cover purely custodial care (the type of care most people in nursing homes need). Generally, Medicare only covers skilled nursing care or skilled rehabilitation care that is provided in a Medicare-certified skilled nursing facility (see page 8 for an explanation of the Medicare benefit for skilled nursing facility care).

Who Sells Long-Term Care Insurance?

Private insurance companies sell long-term care insurance policies. They may sell them to individuals through agents or sometimes through the mail without using agents. Some companies sell coverage through senior citizen organizations, fraternal societies, and other groups or associations. Many employers now make long-term care insurance policies available to their employees, their employees' parents, and their retirees. Insurance companies must be licensed in your State to sell long-term care insurance. Be certain that you are dealing with a company that you know. If you decide to buy long-term care insurance, be sure that the company and the agent, if one is involved, is licensed in your State. If you are not sure, contact your state insurance department (see page 47).

For Your Protection

There are federal penalties for certain violations concerning Medicare supplemental insurance (Medigap) policies. It is, for example, illegal for an insurance agent to say that he or she represents the Medicare program or any other federal agency to sell a policy. It is also illegal for an insurance company or agent to sell you a second Medigap policy unless you tell them in writing that you plan to cancel your existing Medigap policy.

It is illegal for anyone to:

- Sell you a second Medigap policy when they know that you already have one.
- Sell you a Medigap policy if they know you are on Medicaid.
- Sell you a Medigap policy if they know you are enrolled in another Medicare plan other than the Original Medicare Plan.
- Claim that a Medigap policy is federally certified.
- Use the mail to advertise Medigap policies that are not approved for sale in your State.
- Misuse the name, letters, symbols, or emblems of the U.S. Department of Health and Human Services (DHHS), Social Security Administration (SSA), Health Care Financing Administration (HCFA), or any of their various programs.

You should report any suspected violations of the laws governing the marketing of insurance policies to your state insurance department since States are responsible for the regulation of insurance within their boundaries (see page 47).

If you believe that federal law has been violated, you may call the Medicare Hotline at 1-800-638-6833. In most cases, however, your state insurance department can help you with insurance-related problems (see page 47).

Discrimination

Every facility or agency that participates in Medicare must comply with the law. Laws ban discrimination on the basis of race, color, sex, national origin, disability, or age. If you believe that you have been discriminated against based on any of these categories, contact the Department of Health and Human Services Office of Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697.

Who To Contact

Telephone Directory ▶

The following pages have telephone numbers that you can use if you need more information. For numbers not listed in the telephone directory, call the Medicare Hotline at 1-800-638-6833 or look on the internet at www.medicare.gov .

State Insurance Department: Call for questions about the Medicare Supplemental Insurance Policies available in your area. ☎

ALABAMA 1-334-269-3550	DISTRICT OF COLUMBIA 1-202-727-8000	KENTUCKY 1-502-564-3630 or 1-800-595-6053	NEBRASKA 1-402-471-2201	OKLAHOMA 1-800-522-0071 (OK only) or 1-405-521-2828	VERMONT 1-802-828-2900 or 1-800-631-7788 (VT only)
ALASKA 1-907-269-7900	FLORIDA 1-800-342-2762 (FL only) or 1-850-922-3100	LOUISIANA 1-800-259-5301 (LA only) or 1-504-342-5301	NEVADA 1-800-992-0900 (NV only) or 1-702-687-4270	OREGON 1-800-722-4134 (OR only) or 1-503-947-7984	VIRGINIA 1-804-371-9691 1-800-552-7945 (VA only)
AMERICAN SAMOA 011-684-633-4116	GEORGIA 1-404-656-2070 or 1-800-656-2298 (GA only)	MAINE 1-207-624-8475 or 1-800-300-5000	NEW HAMPSHIRE 1-603-271-2261 or 1-800-852-3416	PENNSYLVANIA 1-717-787-2317	VIRGIN ISLANDS 1-809-773-6449 ext. 248
ARIZONA 1-602-912-8444	GUAM 1-0-671-475-1817	MARYLAND 1-410-468-2000	NEW JERSEY 1-609-292-5363 1-800-792-8820 (NJ only)	PUERTO RICO 1-787-722-8686	WASHINGTON 1-360-753-3613 or 1-800-562-6900 (WA only)
ARKANSAS 1-800-852-5494	HAWAII 1-808-586-2790	MASSACHUSETTS 1-617-521-7794	NEW MEXICO 1-505-827-4601 or 1-800-947-4722 (NM only)	RHODE ISLAND 1-800-222-2223 or 1-401-222-2880	WEST VIRGINIA 1-304-558-3386 or 1-800-642-9004 (WV only) or TDD 1-800-435-7381
CALIFORNIA 1-800-927-4357 (CA only, except Los Angeles) or 1-213-897-8921 (Los Angeles and out-of-state calls)	IDAHO 1-800-247-4422 (ID only) or 1-208-334-4250	MICHIGAN 1-517-373-0240	NEW YORK 1-800-342-3736 (NY only)	SOUTH CAROLINA 1-800-768-3467 (SC only) or 1-803-737-6180	WISCONSIN 1-608-266-0103 or 1-800-236-8517 (WI only)
	ILLINOIS 1-217-782-4515	MINNESOTA 1-612-296-4026	NORTH CAROLINA 1-800-443-9354 (NC only) or 1-919-733-0111	SOUTH DAKOTA 1-605-773-3656	WYOMING 1-307-777-7401 or 1-800-438-5768 (WY only)
COLORADO 1-800-930-3745 (CO only)	INDIANA 1-800-622-4461 or 1-317-232-2385	MISSISSIPPI 1-601-359-3569 or 1-800-562-2957	NORTH DAKOTA 1-701-328-2440 or 1-800-247-0560 (ND only)	TENNESSEE 1-800-525-2816 or 1-615-741-4955	
CONNECTICUT 1-860-297-3800	IOWA 1-515-281-5705 or 1-515-281-6867	MISSOURI 1-800-726-7390 or 1-573-751-2640	NORTHERN MARIANA ISLANDS Not Available	TEXAS 1-800-252-3439 or 1-512-463-6515	
DELAWARE 1-302-739-6266	KANSAS 1-800-432-2484 (KS only) or 1-785-296-3071	MONTANA 1-406-444-2040 or 1-800-332-6148 (MT only)	OHIO 1-800-686-1526 (OH only) or 1-614-644-2673	UTAH 1-801-538-3805	

State Health Insurance Assistance Program: Call for assistance with Medicare bills, questions about buying a Supplemental Insurance Policy or long term care insurance, dealing with payment denials or appeals, Medicare rights and protections, help with complaints about your care or treatment, or for help choosing a Medicare health plan.

ALABAMA 1-800-243-5463 (AL only) or 1-334-242-5743	FLORIDA 1-800-963-5337 or 1-850-414-2060	KENTUCKY 1-502-564-7372	MONTANA 1-406-444-7781 or 1-800-332-2272 (MT only)	OHIO 1-614-644-3458	TEXAS 1-800-252-9240
ALASKA 1-800-478-6065 (AK only) or 1-907-269-3680	GEORGIA 1-800-669-8387	LOUISIANA 1-800-259-5301 or 1-504-342-0825	NEBRASKA 1-402-471-2201	OKLAHOMA 1-800-763-2828 (OK only) or 1-405-521-6628	UTAH 1-800-439-3805 (UT only) or 1-801-538-3910
AMERICAN SAMOA 1-808-586-7299	GUAM 1-808-586-7299	MAINE 1-800-750-5353	NEVADA 1-800-307-4444 or 1-702-486-3478	OREGON 1-800-722-4134 (OR only) or 1-503-947-7984	VERMONT 1-800-642-5119 (VT only) or 1-802-748-5182
ARIZONA 1-800-432-4040 or 1-602-542-6595	HAWAII 1-808-586-7299	MARYLAND 1-800-243-3425 (MD only) or 1-410-767-1100 TTY: 1-410-767-1083	NEW HAMPSHIRE 1-603-225-9000	PENNSYLVANIA 1-800-783-7067	VIRGINIA 1-800-552-3402 (VA only) or 1-804-662-9333
ARKANSAS 1-800-852-5494 or 1-501-371-2782	IDAHO 1-800-247-4422 (Boise) 1-800-488-5725 (Lewiston) 1-800-488-5731 (Twin Falls) 1-800-488-5764 (Pocatello)		NEW JERSEY 1-800-792-8820 or 1-877-222-3737 (NJ only)	PUERTO RICO 1-877-725-4300 or 1-787-721-8590	VIRGIN ISLANDS 1-809-778-6311 ext.2338
CALIFORNIA 1-800-510-2020 (CA only) or 1-916-323-7315 (out of state)		MASSACHUSETTS 1-800-882-2003	NEW MEXICO 1-800-432-2080 (NM only) or 1-505-827-7640	RHODE ISLAND 1-401-222-2880 or 1-800-322-2880 (RI only)	WASHINGTON 1-800-397-4422 (WA only) or 1-360-407-0383
COLORADO 1-800-544-9181 (CO only) or 1-303-894-7499 ext. 356	ILLINOIS 1-800-548-9034 (IL only) or 1-217-785-9021	MICHIGAN 1-800-803-7174	NEW YORK 1-800-333-4114 or 1-212-869-3850 (New York City)	SOUTH CAROLINA 1-800-868-9095 (SC only) or 1-803-253-6177	WEST VIRGINIA 1-877-987-4463 or 1-304-558-3317
CONNECTICUT 1-800-994-9422 (CT only) or 1-860-424-5245 (out-of-state)	INDIANA 1-800-452-4800 (IN only) or 1-317-233-3475	MINNESOTA 1-800-333-2433	NORTH CAROLINA 1-800-443-9354 (NC only) or 1-919-733-0111	SOUTH DAKOTA 1-800-822-8804 (SD only) 1-605-773-3656 (Pierre) 1-605-336-2475 (Sioux Falls) 1-605-342-3494 (Rapid City)	WISCONSIN 1-800-242-1060 (WI only) or 1-877-333-0202
DELAWARE 1-800-336-9500 (DE only) or 1-302-739-6266	IOWA 1-800-351-4664	MISSISSIPPI 1-800-948-3090 or 1-601-359-4929	NORTH DAKOTA 1-800-247-0560 or 1-701-328-2977		WYOMING 1-800-856-4398 or 1-307-856-6880
DISTRICT OF COLUMBIA 1-202-676-3900	KANSAS 1-800-860-5260 (KS only) or 1-316-337-7386	MISSOURI 1-800-390-3330	NORTHERN MARIANA ISLANDS 1-808-586-7299	TENNESSEE 1-800-525-2816 or 1-615-741-4955	

Health Care Financing Administration (HCFA) Regional Offices: Call for information about local seminars and health fairs on Medicare health plan choices, or to report a complaint directly to HCFA. ☎

If you live in:	The Regional Office is in:	The phone number is:
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Boston	1-617-565-1232
New York, New Jersey, Puerto Rico, Virgin Islands	New York	1-212-264-3657
Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	Philadelphia	1-215-861-4226
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	Atlanta	1-404-562-7500
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Chicago	1-312-353-7180
Arkansas, Louisiana, New Mexico, Oklahoma, Texas	Dallas	1-214-767-6401
Iowa, Kansas, Missouri, Nebraska	Kansas City	1-816-426-2866
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Denver	1-303-844-4024
American Samoa, Arizona, California, Guam, Hawaii, Nevada, Northern Mariana Islands	San Francisco	1-415-744-3602
Alaska, Idaho, Oregon, Washington	Seattle	1-206-615-2354

Agencies On Aging: These agencies are responsible for coordinating services for older persons.

ALABAMA 1-800-243-5463	DISTRICT OF COLUMBIA 1-202-724-5622	KENTUCKY 1-502-564-6930	NEBRASKA 1-402-471-2306	OKLAHOMA 1-405-521-2327	VERMONT 1-802-241-2400
ALASKA 1-907-269-3680	FLORIDA 1-850-414-2000	LOUISIANA 1-504-342-7100	NEVADA 1-702-486-3545	OREGON 1-800-232-3020	VIRGINIA 1-804-662-9333
AMERICAN SAMOA 1-684-633-1252	GEORGIA 1-404-657-5258	MAINE 1-207-624-5335	NEW HAMPSHIRE 1-603-271-4680	PENNSYLVANIA 1-717-783-1550	VIRGIN ISLANDS 1-809-692-5950
ARIZONA 1-602-542-4446	GUAM 011-671-475-0263	MARYLAND 1-800-243-3425	NEW JERSEY 1-609-588-3139	PUERTO RICO 1-787-721-5710	WASHINGTON 1-360-586-8753
ARKANSAS 1-501-682-2441	HAWAII 1-808-586-0100	MASSACHUSETTS 1-617-727-7750	NEW MEXICO 1-505-827-7640	RHODE ISLAND 1-401-222-2858	WEST VIRGINIA 1-304-558-3317
CALIFORNIA 1-916-322-5290	IDAHO 1-208-334-2423	MICHIGAN 1-517-373-8230	NEW YORK 1-800-342-9871	SOUTH CAROLINA 1-803-253-6177	WISCONSIN 1-608-266-2536
COLORADO 1-303-620-4147	ILLINOIS 1-217-785-3356	MINNESOTA 1-800-882-6262	NORTH CAROLINA 1-919-733-3983	SOUTH DAKOTA 1-605-773-3656	WYOMING 1-307-777-7986
CONNECTICUT 1-800-443-9946	INDIANA 1-317-232-7020	MISSISSIPPI 1-601-359-4929	NORTH DAKOTA 1-800-755-8521	TENNESSEE 1-615-741-2056	
DELAWARE 1-800-223-9074	IOWA 1-515-281-5187	MISSOURI 1-573-751-3082	NORTHERN MARIANA ISLANDS 1-607-234-6011	TEXAS 1-512-424-6840	
	KANSAS 1-913-296-4986	MONTANA 1-406-444-7781	OHIO 1-614-466-5500	UTAH 1-801-538-3910	

Medicare Carriers: Call for questions on Part B coverage, bills, and medical services, or for information on how to recognize Medicare fraud and abuse. ☎

ALABAMA
Blue Cross/Blue Shield of Alabama, 1-800-292-8855 or 1-205-988-2244

ALASKA
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

AMERICAN SAMOA
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

ARIZONA
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

ARKANSAS
Arkansas Blue Cross/Blue Shield, 1-800-482-5525 (AR only) or 1-314-212-1800

CALIFORNIA
Transamerica Occidental Life Insurance, Counties of Los Angeles, Orange, San Diego, Ventura, Imperial, San Luis Obispo, & Santa Barbara
1-800-675-2266 (CA only) or 1-213-748-2311

Rest of State:
National Heritage Insurance Company, 1-800-952-8627 or 1-530-743-1583

COLORADO
Blue Cross/Blue Shield of North Dakota, 1-800-332-6681 or 1-303-831-2661

CONNECTICUT
United HealthCare, 1-800-982-6819 (in CT only) or 1-203-237-8592

DELAWARE
Medicare Customer Service Center, 1-800-444-4606

DISTRICT OF COLUMBIA
Medicare Customer Service Center, 1-800-444-4606

FLORIDA
Blue Cross/Blue Shield of Florida, 1-800-333-7586 (FL only)

GEORGIA
Cahaba, 1-800-727-0827 or 1-912-927-0934

GUAM
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

HAWAII
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

IDAHO
CIGNA Medicare, 1-800-627-2782 (ID only) or 1-615-244-5650

ILLINOIS
Wisconsin Physicians Service (WPS) 1-800-642-6930 or 1-312-938-8000 or TDD 1-800-535-6152

INDIANA
AdminaStar Federal, 1-800-622-4792 or 1-317-842-4151

IOWA
Wellmark Inc. Blue Cross/Blue Shield of Iowa, 1-515-245-4785 or 1-800-532-1285

KANSAS
Blue Cross/Blue Shield of Kansas, 1-800-432-3531 or 1-785-291-4000 (in Topeka) or 1-800-432-0216 (out of state)

KENTUCKY
AdminaStar Federal, 1-800-999-7608 or 1-502-425-6759

LOUISIANA
Arkansas Blue Cross/Blue Shield, Inc., 1-800-462-9666 or Baton Rouge 1-504-927-3490

MAINE
National Heritage Insurance Company, 1-800-492-0919 or 1-781-741-5256

MARYLAND
Medicare Customer Service Center, 1-800-444-4606

MASSACHUSETTS
National Heritage Insurance Company, 1-800-882-1228 or 1-781-741-5256

MICHIGAN
Wisconsin Physicians Service (WPS) 1-800-482-4045

MINNESOTA
United HealthCare Insurance Co., 1-800-352-2762 (MN only) or 1-612-884-7171

MISSISSIPPI
United HealthCare Insurance, 1-800-682-5417 (MS only) or 1-601-956-0372

MISSOURI
Blue Cross/Blue Shield of Kansas (Kansas City area) 1-800-892-5900 or 1-816-561-0900; Arkansas Blue Cross/Blue Shield (rest of state) 1-800-322-6670 or 1-314-212-1800

Medicare Carriers: Call for questions on Part B coverage, bills, and medical services, or for information on how to recognize Medicare fraud and abuse. ☎

MONTANA
Blue Cross/Blue Shield of Montana, 1-800-332-6146 (MT only) or 1-406-444-8350

NEBRASKA
Blue Cross/Blue Shield of Kansas, 1-800-633-1113

NEVADA
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

NEW HAMPSHIRE
National Heritage Insurance Company, 1-800-882-1228 or 1-781-741-5256

NEW JERSEY
Xact Medicare Service, 1-800-462-9306

NEW MEXICO
Arkansas Blue Cross/Blue Shield, 1-800-423-2925 or 1-505-872-2551

NEW YORK
Empire BC/BS: Bronx, Brooklyn, Columbia, Delaware, Dutchess, Greene, Manhattan, Nassau, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Ulster & Westchester, 1-800-442-8430
Group Health Ins.: Queens, 1-212-721-1770
BC/BS of Western NY, 1-800-252-6550

NORTH CAROLINA
CIGNA, 1-800-672-3071 or 1-336-665-0348

NORTH DAKOTA
Blue Shield of North Dakota, 1-800-332-6681 or 1-800-247-2267 or 1-701-277-2363

NORTHERN MARIANA ISLANDS
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

OHIO
Nationwide Mutual Insurance Co., 1-800-282-0530 or 1-614-249-7157

OKLAHOMA
Arkansas Blue Cross/Blue Shield, 1-800-522-9079 or 1-405-848-7711

OREGON
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

PENNSYLVANIA
Xact Medicare Services, 1-800-382-1274

PUERTO RICO
Triple-S, Inc., 1-800-981-7015 in Puerto Rico
In a Metro Area, 1-787-749-4900

RHODE ISLAND
Blue Cross/Blue Shield of Rhode Island, 1-800-662-5170 (only in RI) or 1-401-861-2273

SOUTH CAROLINA
Blue Cross/Blue Shield of South Carolina, 1-800-868-2522 or 1-803-788-3882

SOUTH DAKOTA
Blue Cross/Blue Shield of North Dakota, 1-701-277-2363

TENNESSEE
CIGNA Medicare, 1-800-342-8900 (TN only) or 1-615-244-5650

TEXAS
Blue Cross/Blue Shield of Texas, 1-800-442-2620

UTAH
Blue Cross/Blue Shield of Utah, 1-800-426-3477 or 1-801-333-2430

VERMONT
National Heritage Insurance Company, 1-800-447-1142 or 1-781-741-5256

VIRGINIA
Medicare Customer Service Center-Counties of Arlington and Fairfax, 1-800-444-4606
United HealthCare (rest of state), 1-800-552-3423 or 1-804-330-4786

VIRGIN ISLANDS
Triple-S, Inc., 1-800-474-7448 (VI only)

WASHINGTON
Blue Cross/Blue Shield of North Dakota, 1-800-444-4606

WEST VIRGINIA
Nationwide Mutual Insurance Co., 1-800-848-0106 or 1-614-249-7157

WISCONSIN
Medicare/WPS, 1-800-944-0051 (WI only) or 1-608-221-3330 or TTY/TDD: 1-800-828-2837

WYOMING
Blue Cross/Blue Shield of North Dakota, 1-800-442-2371 or 1-307-632-9381

New Medicare Health Plan Choices

Congress passed a law in 1997 that made many changes in the Medicare program. The law includes a section called Medicare + Choice, which creates new health plan options. You can continue to receive Medicare benefits as you do now, or you may be able to change to a plan that gives you at least the same (possibly more) benefits. The choice is yours.

What are the Medicare Health Plans?

Medicare now offers more health plan choices in addition to the Original Medicare Plan. However, they all may not be available in your area. These choices may include:

Original Medicare Plan

The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan. Medicare pays its share of the bill and you pay the balance of the Medicare-approved payment amount.

Original Medicare Plan with a Supplemental Insurance (Medigap) Policy

The traditional pay-per-visit arrangement that covers Part A and Part B services is now called the Original Medicare Plan. You can buy one of ten standardized Medicare supplemental insurance policies (Medigap or Medicare SELECT). These policies provide extra benefits and help cover some of your out-of-pocket costs (see page 12).

Medicare Managed Care Plan

A Medicare Managed Care Plan is a group of doctors, hospitals, and other health care providers who have agreed to provide care to Medicare beneficiaries in exchange for a fixed amount of money from Medicare every month. Medicare Managed Care Plans include Health Maintenance Organizations (HMOs), Health Maintenance Organizations with a Point of Service option (HMOs With POS), Provider Sponsored Organizations (PSOs), and Preferred Provider Organizations (PPOs).

Private Fee-for-Service Plan

A Private Fee-for-Service Plan is a private insurance plan that accepts Medicare beneficiaries. You may go to any doctor or hospital you want. The insurance plan, rather than the Medicare program, decides how much to pay for the services you receive. You may have extra benefits the Original Medicare Plan doesn't cover, but you may also face higher charges from doctors and other providers. This is not the same as the Original Medicare Plan.

New Medicare Health Plan Choices continued:

Medicare Medical Savings Account (MSA) Plan

This is a test program for approximately one percent (up to 390,000) of eligible Medicare beneficiaries. You choose a Medicare MSA health policy - a health insurance policy with a high deductible. Medicare pays the premium for the Medicare MSA health policy and makes a deposit to the Medicare MSA that you establish. You use the money deposited in your Medicare MSA to pay for medical expenses. If you don't use all the money in your Medicare MSA, next year's deposit will be added to your balance. Money can be withdrawn from a Medicare MSA for non-medical expenses, but that money will be taxed. If you enroll in a Medicare MSA Plan, you must stay in it for a full year. You can only sign up for a Medicare MSA Plan in November of each year, or during special enrollment periods. Under a Medicare MSA Plan, you may face higher charges from doctors and other providers than in the Original Medicare Plan.

Religious Fraternal Benefit Society Plans

These plans are offered by a Religious Fraternal Benefit Society for members of the society. Only members of the society may enroll. The society must meet Internal Revenue Service (IRS) and Medicare requirements for this type of organization. No other information on Religious Fraternal Benefit Society Plans is available at this time.

For more information about Medicare health plans:

- Look at a copy of the *Medicare & You 1999* handbook.
- This handbook can be found on the Internet at www.medicare.gov.
- Look at Medicare health plan comparison information on the Internet at www.medicare.gov. If you don't have a computer, your local library or senior center may be able to help you access the Medicare website.
- Ask for information on Medicare + Choice health plans available in your area by using the automated Medicare Special Information number at 1-800-318-2596.
- Call your State Health Insurance Assistance Program (see page 48).

* ACTIVITIES OF DAILY LIVING (ADL)	Activities you usually perform in the course of a normal day. Although definitions differ, ADL's are usually considered to be everyday activities such as walking, getting in and out of bed, dressing, bathing, eating, and toileting.
ASSIGNMENT	In the Original Medicare Plan, a process through which a doctor or supplier agrees to accept the amount Medicare approves as payment in full. (You must pay any coinsurance amount.)
BASIC BENEFITS	Benefits provided in Medigap Plan A. They are also included in all the other Medigap plans.
BENEFICIARY	A person who gets health care insurance through the Medicare program.
BENEFIT PERIOD	A way to measure your use of hospital and skilled nursing facility services covered by Medicare. A benefit period begins the day you go to a hospital or skilled nursing facility. It ends after you haven't received hospital or skilled nursing care for 60 days in a row. If you go into the hospital after 60 days, a new benefit period begins. Most Medicare Part A benefits are renewed. You must pay a new inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods a beneficiary can have. (See Lifetime Reserve Days.)
BENEFITS	The money or services provided by an insurance policy. In a health plan, benefits take the form of health care.
COINSURANCE	The percentage of the Medicare-approved charge that you have to pay; after you pay the Part A deductible; and after you pay the $100 deductible each year for Part B.
* CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) OF 1985	This law requires an employer to allow you to remain covered under the employer's group health plan for a certain length of time after losing your job or having your work hours reduced, or after your spouse's death or a divorce. However, you may have to pay both your share and the employer's share of the premium.
COORDINATION OF BENEFITS CLAUSE	A written statement that tells which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare plan, federal law may decide who pays first.
COPAYMENT	In some Medicare health plans, the amount that you pay for each medical service, like a doctor visit.

CREDITABLE COVERAGE	Any previous health insurance coverage that can be credited towards pre-existing condition restrictions.
CUSTODIAL CARE	Personal care such as bathing, cooking, shopping, etc.
DEDUCTIBLE	The amount you must pay before Medicare begins to pay; either each benefit period for Part A, or each year for Part B.
DISENROLL	End your health care coverage with a health plan.
DURABLE MEDICAL EQUIPMENT	Medical equipment that is ordered by a doctor for use in the home. These items must be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under Part B. You pay a 20% coinsurance payment.
* END-STAGE RENAL DISEASE (ESRD)	Kidney failure that is severe enough to require lifetime dialysis or a kidney transplant. ESRD patients are eligible for Medicare, and may be eligible for Social Security payments if found to be disabled.
* EXCESS CHARGE (MEDIGAP)	The difference between a doctor's or other healthcare provider's actual charge (up to the amount of charge limitation set by Medicare or the state) and the Medicare-approved payment amount.
EXCLUSION PERIOD	A period of time of up to 6 months when an insurance company can delay coverage of a pre-existing condition.
FISCAL INTERMEDIARY	A private company that has a contract with Medicare to pay bills for Part A hospital services.
GAPS	The costs or services that are not covered under the Original Medicare Plan.
GUARANTEED RENEWABLE	A Medigap policy that your insurance company must allow you to renew, unless you do not pay the premiums.
HEALTH CARE FINANCING ADMINISTRATION (HCFA)	The federal agency that runs the Medicare, Medicaid, and Children's Health Insurance Program, and works to make sure that the beneficiaries in these programs have access to high quality health care.
HOME HEALTH CARE	Medical care that is provided at home, such as physical therapy or skilled nursing care. It is different from at-home recovery care (see page 17) which is help with bathing, eating, and other activities of daily living. (See Activities of Daily Living.)
HOSPITAL INSURANCE (PART A)	Part of Medicare that covers inpatient hospital stay, skilled nursing facilities, home health care, and hospice care. (See Medicare Part A.)

LIFETIME RESERVE DAYS	60 lifetime days that Medicare will pay for when you are put in a hospital for more than 90 days. These 60 reserve days can be used only once during your lifetime. For each lifetime reserve day, Medicare pays all covered costs except for a daily coinsurance ($384 in 1999).
LIMITING CHARGE	The maximum amount doctors and other health care providers who don't accept assignment can charge you for a covered service. The limit is 15% over Medicare's approved payment amount.
LONG-TERM CARE	Custodial care provided at home or in a nursing home for people with chronic disabilities and prolonged illnesses. It is not covered by Medicare. You can buy long-term care insurance coverage from a private insurance company.
MEDICAID	A joint Federal and State program that helps with medical costs for some people with low incomes. Programs vary from State to State, but most health care costs are covered if you qualify for both Medicare and Medicaid.
MEDICAL INSURANCE (PART B)	Part of Medicare that covers doctors' services, outpatient hospital care, and other medical services that Part A doesn't cover, such as the services of physical and occupational therapists. (See Medicare Part B.)
MEDICAL UNDERWRITING	The process that a company uses to determine whether or not to accept your application for insurance and how much to charge you for that insurance.
MEDICARE	A health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with End-Stage Renal Disease (ESRD), (people with permanent kidney failure who need dialysis or a transplant).
MEDICARE CARRIER	A private company that contracts with Medicare to process beneficiary bills (claims) for Part B services.
MEDICARE COVERAGE	Consists of two parts: Hospital Insurance (Part A) and Medical Insurance (Part B).
MEDICARE PART A (HOSPITAL INSURANCE)	Hospital insurance that pays for inpatient hospital stay, care in a skilled nursing facility, home health care, and hospice care. (See Hospital Insurance.)
MEDICARE PART B (MEDICAL INSURANCE)	Medical insurance that helps pay for doctors' services, outpatient care, and other medical services that are not covered by Part A. (See Medical Insurance.)

Glossary Of Terms

MEDICARE SELECT	A type of Medigap policy that must meet all of the requirements that apply to a Medigap policy. You may be required to use doctors and hospitals within its network in order to be eligible for full benefits.
MEDIGAP	A Medicare supplemental insurance policy that is sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. There are ten standardized policies, labeled Plan A through Plan J. Medigap policies only work with the Original Medicare Plan.
OPEN ENROLLMENT (MEDIGAP)	A one-time only, six-month period after you enroll in Medicare Part B, and are 65 or older, when you can purchase any Medigap plan you want. You cannot be denied coverage due to your medical history during this time.
OUT-OF-POCKET COSTS	Health care costs that you must pay on your own because they are not covered by Medicare.
PRE-EXISTING CONDITION/MEDIGAP	Health problems that required medical treatment within the 6 months before the date that the policy went into effect.
PREMIUM	Periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.
PREVENTIVE CARE	Care to keep you healthy or prevent illness, such as routine checkups and some tests like colorectal cancer screening, yearly mammograms, and flu shots.
PRIMARY PAYER	The insurance company that pays first on a claim for medical care. This could be Medicare or other insurance.
PROTECTIONS AND GUARANTEES	Your rights to buy Medigap coverage in certain cases.
PROVIDER	A doctor, hospital, health care professional, or health care facility.
SECONDARY PAYER	The insurance company that pays second on a claim for medical care. This could be Medicare, Medicaid, or other insurance depending on the circumstances.
SKILLED NURSING FACILITY (SNF)	A facility that provides skilled nursing or rehabilitation services to help you recover after a hospital stay.
WAITING PERIOD	The time between when you sign-up with a Medigap insurance company or Medicare health plan and when your coverage starts.

* This definition, whole or in part, was used with permission from Walter Feldesman, Esq., Dictionary of Eldercare Terminology, 1997.

For Your Notes

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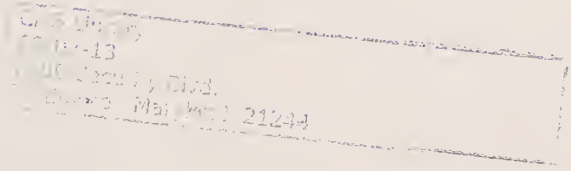

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Health Care Financing Administration
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Baltimore, Maryland 21244-1850

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Health Care Financing Administration

Audio tapes in English and Spanish, Braille in English, and Spanish copies of the *1999 Guide to Health Insurance for People with Medicare* are available (call 1-800-638-6833).

¿Necesita usted una copia en Español o en audio-cassette del manual de *La Guía de Seguro de Salud para personas con Medicare*? (Llame al 1-800-638-6833.)

*U.S. G.P.O.:1999-771-410